

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1945

## CERTIFICATE OF DEATH

Reg. Dist. No.

01930

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <b>Rural Drayden</b>	
X <b>Rural Drayden</b>		<b>Life</b>		STREET ADDRESS (If rural give location)		X <b>Rural Drayden</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		1	
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
<b>Joseph A.</b>				<b>Barnes</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <b>Feb. 25, 1875</b>	
						9. AGE last birthday: <b>79</b> yrs.	
						10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>18</b> Hours <b>18</b> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Labor</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Daywork</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
13. FATHER'S NAME: <b>John A. Barnes</b>				14. MOTHER'S MAIDEN NAME: <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>9 #</b>				16. SOCIAL SECURITY NO. <b>#####</b>		17. INFORMANT & ADDRESS: <b>Josephine Barnes Drayden, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>421.4</b>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <b>Chronic Valvular Heart Disease</b>						<b>4 years</b>	
(B) <b>Coronary Embolism</b>						<b>4 days</b>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov</b> , 1950, to <b>Feb 11</b> , 1955, that I last saw the deceased alive on <b>Feb 10, 1955</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>P. J. Beary M.D.</b>				ADDRESS <b>Great Mills, Md.</b>			
DATE SIGNED <b>2-12-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2/15/55</b>		<b>St Marks</b>		<b>Valley Lee Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>Feb 13/55</b>		<b>P. J. Beary M.D.</b>		<b>Jos. C. Mattingley</b>		<b>Leonardtown, Md.</b>	

BUREAU V. S.

13 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01932  
1946 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Marys</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Marys</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>X Leonardtown</i>		<i>9 days</i>		<i>St Georges Island X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>78 St Marys Hospital</i>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <i>Feb 18 1955</i>			
<i>Howard J Chesser</i>							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>Male</i>		<i>White</i>		<i>married</i>		<i>Sept-1-1885</i>	
						9. AGE last birthday	
						<i>69 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<i>Waterman</i>				<i>Oyster + crab Maryland St Marys</i>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<i>U. S. A.</i>				<i>U. S. A.</i>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>William C. Chesser</i>				<i>Anna Wootton</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<i>9</i>							
17. INFORMANT & ADDRESS:							
<i>Mrs Howard J. Chesser</i>				<i>St Georges Island</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A)				<i>Uremia</i>			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <i>Arteriosclerotic CV disease</i>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Coronary thrombosis</i>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
OF INJURY				While <input type="checkbox"/> Not while <input type="checkbox"/>			
				M. at work at work			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 11, 1955</i> , to <i>Feb 18, 1955</i> , that I last saw the deceased alive on <i>Feb 8, 1955</i> , and that death occurred at <i>5:50 A.M.</i> from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
<i>Way Luther, M.D.</i>				<i>Neuchamondville Rd 2/19/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF			
<i>Burial</i>				<i>Feb 21-55</i>			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
<i>M.E. Methodist</i>				<i>St Georges Island, Md</i>			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE			
<i>2/20/55</i>				<i>P. B. Brann, M.D.</i>			
24. FUNERAL DIRECTOR				ADDRESS			
<i>Joe C. Mattingley</i>				<i>Leonardtown Md</i>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 24 1955

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1947

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01933

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

Item 9 File 0178 3-7-55 et

1. PLACE OF DEATH COUNTY <u>St Mary's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hermansville</u> TOWN <u>Hermansville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3 Natch Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Mary's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hermansville, Md.</u> TOWN <u>Hermansville</u> STREET ADDRESS <u>3 Natch Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Beulah Virginia Gross</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6/1/06</u>
9. AGE last birthday <u>48</u> yrs.		10. If under 1 year: Months <u>11</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsburg PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Senora P. Nicholas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>193-22-3924</u>	
17. INFORMANT AND ADDRESS <u>Harriet B. Coleman - Sister</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>170X Immediate cause</u> (a) <u>Respiratory Depression</u> (b) <u>Pulmonary Edema</u> (c) <u>Progressive Cardiac Failure</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 day</u> <u>1 wk.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Rt. Breast &amp; Metastasis</u>		20. AUTOPSY? <u>2 yrs.</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
21. ACCIDENT (Specify) SUICIDE <u>None</u> HOMICIDE <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u> INJURY <u>None</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> Not While At-work <input checked="" type="checkbox"/> <u>None</u>	
22. I hereby certify that I attended the deceased from <u>Aug. 15, 1954</u> to <u>Feb. 28, 1955</u> , that I last saw the deceased alive on <u>Feb. 26, 1955</u> , and that death occurred at <u>8:00 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Henley B. Johnson, M.D.</u>		ADDRESS <u>10 Van Buren St.</u>	
DATE SIGNED <u>2/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-3-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peter's Church</u>		LOCATION (City, town, or county) (State) <u>St. Mary's Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/3/55</u>		REGISTERAR'S SIGNATURE <u>Robt. L. Locke</u>	
24. FUNERAL DIRECTOR <u>P. E. Sewell</u>		ADDRESS <u>Pr. Frederick</u>	

md

RECEIVED

MAR 4 1955

BUREAU V. 3

1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>St. Mary's</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>St. Mary's</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Lexington Park</i>	LENGTH OF STAY (in this place) <i>10 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Lexington Park</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Haynes</i>	(Middle) <i>Donley</i>	(Last) <i>Hart</i>	(Month) <i>2</i> (Day) <i>27</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Cauc.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>3-28-1906</i>
9. AGE last birthday: <i>48</i> yrs.		10. MONTHS <i>11</i> DAYS <i></i> HOURS <i></i> MIN. <i></i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Industrial</i>	
11. BIRTHPLACE (State or foreign country): <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John F. Hart</i>		14. MOTHER'S MAIDEN NAME: <i>Minnie Lee Tigue</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>233-07-4168</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Leonard Cochran, Jr., Tall Timber, Md.</i>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>421.4</i>		
Immediate cause		<i>immediate</i>
(a) <i>Cerebral embolism</i>		
DUE TO		
Antecedent causes (s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<i>10 yrs.</i>
(b) <i>Chronic Valvular Heart Disease</i>		
DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY?		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?
OF INJURY	While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from *September 25, 1954*, to *2-27, 1955*, that I last saw the deceased alive on *Feb 24, 1955*, and that death occurred at *3 P.M.*, from the causes and on the date stated above.

SIGNATURE <i>P. J. Bean, M.D.</i>	ADDRESS <i>Great Mills Md</i>	DATE SIGNED <i>2-28-55</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Removal</i>	<i>March 3, 55</i>	<i>Wood Cemetery</i>
LOCATION (City, town, or county) (State)		
<i>West Va.</i>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>2-28-1955</i>	<i>P. J. Bean, M.D.</i>	<i>George Cook, Cedar Groove, W. Va.</i>
	<i>Local Registrar</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01935

1949

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Mary's</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <i>Leonardtown</i>		<i>10</i>		STREET ADDRESS (If rural give location)		<i>1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St Mary's Hospital</i>							
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Mary Rose Louise Herbert</i>				<i>Feb 7 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>Celoid</i>	<i>Widowed</i>	<i>July 29 - 1877</i>	<i>77</i> yrs.	<i>7</i> Months	<i>11</i> Days	<i>11</i> Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>House wife</i>						<i>St Mary's Co Md</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Joseph Forest</i>				<i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>g</i>						<i>Richard Billingsley Herbert maddot Md</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <i>Cerebral Vascular accident</i>				<i>2 wk</i>			
ANTECEDENT CAUSE (B) <i>Arteriosclerosis</i>				<i>5 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<i>0</i>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <i>4/19</i> , 1955, to <i>2/7</i> , 1955, that I last saw the deceased alive on <i>2/5</i> , 1955, and that death occurred at <i>1045</i> M, from the causes and on the date stated above.							
SIGNATURE <i>MD Byrd</i>				ADDRESS <i>Leonardtown</i>		DATE SIGNED <i>2/7/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Feb 10 - 55</i>		<i>Sacred Heart</i>		<i>Bush Wood Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2/7/55</i>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<i>Joe C. Mattingley</i>		<i>Leonardtown</i>	

RECEIVED  
FEB 9 1955  
BUREAU V. S.

1950

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>St Mary's</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>St Mary's</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hollywood</i>	LENGTH OF STAY (in this place) <i>3 months 4 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hollywood</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(Type or Print)	(First) (Middle) (Last)	<i>Feb. 28 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH: <i>Nov. 23 1954</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <i>3 yrs. 3 months 4 days</i>
13. FATHER'S NAME: <i>George Wallace Latham</i>		14. MOTHER'S MAIDEN NAME: <i>Violet Elizabeth Heard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS: <i>George W. Latham Hollywood, Md.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Bone pneumonia</i>			<i>1 day</i>
ANTECEDENT CAUSE (S) (B) <i>Acute bronchitis</i>			<i>5 days</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 25, 1955</i> , to <i>Feb 28, 1955</i> , that I last saw the deceased alive on <i>Feb 27, 1955</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>M. D. [Signature]</i>		DATE SIGNED <i>Feb 28/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>St Aloysius</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb 28/55</i>		LOCATION (City, town, or county) (State) <i>Leonardtown, Md.</i>	
REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR ADDRESS <i>for C. Mattingley Leonardtown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01938

1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Mary's</i>	
CITY (If outside corporate limits, write OR and give nearest town) <i>Compton</i>		LENGTH OF STAY (in this place) <i>65 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Compton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>Helen</i> (Middle) <i>Lucas</i> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb. 3 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>		8. DATE OF BIRTH: <i>Feb. 2 1860</i>	
9. AGE last birthday: <i>95</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <i>Housewife</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>A. L. Martin</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>9</i> (If Yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT'S ADDRESS: <i>Sidney Lucas Compton, Md</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>501X Fibrillation of heart age</i>							
ANTECEDENT CAUSE (S) (B) <i>Bronchitis &amp; loss of appetite</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased <i>many yrs ago</i> , 19 <i>1908</i> , that I last saw the deceased alive on <i>May 15, 1955</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>H. F. Greenwell</i>				DATE SIGNED <i>Feb 3 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>Feb 5 1955</i>			
NAME OF CEMETERY OR CREMATORY <i>St Paul</i>				LOCATION (City, town, or county) (State) <i>Leonardtown Md</i>			
DATE REC'D BY LOCAL REGISTRAR <i>4-5-55</i>				REGISTRAR'S SIGNATURE <i>Robt. J. Locke</i>			
24. FUNERAL DIRECTOR				ADDRESS <i>Joe C. Mallingby Leonardtown Md</i>			

BUREAU V. 31

FEB 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1952  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Saint Mary's		MARYLAND		STATE Maryland		COUNTY Saint Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN Mechanicsville				TOWN Mechanicsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				Rural			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
William		Isaac		Lyles		February 19, 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Negro		Married		1900	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
54 yrs.		Tenant		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Clarence Lyles				Catherine Jenifer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
				229-16-3645		Florine Lyles :::: Mechanicsville, Md.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
912.1 Immediate cause (a) Cerebral hemorrhage						1 day	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) run over by trailer truck.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. exposure for 4 hrs.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
None							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		None		Mechanicsville, St. Mary's, Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
2 19 55 PM				fell off truck & run over by trailer			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER			
				DEPUTY MEDICAL EXAMINER			
				M. D. DATE SIGNED			
				2/21/55			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/23/55		All Faith Cemetery		Charlotte Hall, Md.	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-23-1955		Robert F. Locke		P. B. Robinson ::::		Leonardtwn, Md.	

RECEIVED FEB 24 1955

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

[Extremely faint and mostly illegible typed text, likely a memorandum or report body.]

BUREAU V. A.

FEB 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1953

01940

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Marys</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Marys</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN <i>Leonardtown</i>	
X <i>Leonardtown</i>		<i>2 Days</i>		STREET ADDRESS (If rural give location)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St Marys Hospital</i>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Adriana C. Maddox</i>				OF DEATH: <i>Feb 14 1953</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>Oct 12 1869</i>	<i>85 yrs.</i>	<i>4</i> Months	<i>2</i> Days	<i>0</i> Hours <i>0</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>House wife</i>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland St Marys</i>	
13. FATHER'S NAME: <i>Joseph T. Gough</i>				14. MOTHER'S MAIDEN NAME: <i>Elizabeth Roach</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<i>9</i>				<i>Mr John H. J. Bruce Leonardtown Md</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<i>30 hours.</i>			
443X IMMEDIATE CAUSE (A) <i>Cerebrovascular accident.</i>							
ANTECEDENT CAUSE (S) (B) <i>Hypertensive cardiovascular disease.</i>				<i>10 yrs.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<i>0</i>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May</i> , 1953 to <i>Feb.</i> , 1955 that I last saw the deceased alive on <i>14 Feb</i> , 1955, and that death occurred at <i>6:30 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Joseph E. Gill</i>		ADDRESS <i>Leonardtown, Md</i>		DATE SIGNED <i>2/15/55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Feb 16 55</i>		<i>St Aloysious</i>		<i>Leonardtown Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-16-55</i>		REGISTRAR'S SIGNATURE <i>R. F. Locke</i>		24. FUNERAL DIRECTOR <i>Jos C. Mallingley</i>		ADDRESS <i>Leonardtown Md</i>	

RECEIVED  
FEB 23 1955  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1954

01941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St Marys</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St Marys</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Leonardtown</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Leonardtown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>R.F. D # 1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Joseph</u>	(Middle) <u>A.</u>	(Last) <u>Neal</u>	(Month) <u>Feb</u> (Day) <u>16</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married Oct 16 - 1948</u>	8. DATE OF BIRTH: <u>48</u> yrs. <u>48</u> Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labor State road</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Maryland St Marys</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Paul Neal</u>		14. MOTHER'S MAIDEN NAME: <u>Agnes Florentine Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>W. Paul Neal, Leonardtown Md</u>	
16. SOCIAL SECURITY No.:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
<p>916.0            Immediate cause (a) <u>2nd degree burns of entire body</u>            DUE TO</p> <p>Antecedent cause(s) (b)            Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>			<u>immediate</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19a. DATE OF OPERATION: <u>0 none</u>		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>None</u>	21c. (City or town) <u>Leonardtown</u> (County) <u>St. Marys</u> (State) <u>MD</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>16</u> <u>55</u> <u>4</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>burned house fire</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>[Signature]</u>		M. D. CHIEF MEDICAL EXAMINER <u>[Signature]</u> DEPUTY MEDICAL EXAMINER <u>[Signature]</u> ASSISTANT MEDICAL EXAM. <u>[Signature]</u> DATE SIGNED <u>2/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>Feb 18 1955</u>	NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	LOCATION (City, town, or county) (State) <u>Holly Wood Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 17/55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Leonardtown Md</u>	

RECEIVED  
FEB 21 1955  
BUREAU V. S.

RECEIVED

FEB 21 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1955

## CERTIFICATE OF DEATH

01942

Reg. Dist. No.

Item 9 Film G178 3-9-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Mary's</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>St Mary's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Leonardtwn</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural California</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>78 St Mary's Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mamie Otterback</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 11 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Sept. 19, 1879</u>	
9. AGE last birthday: <u>76</u> yrs.		10. AGE last birthday: <u>4</u> Months		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>			
13. FATHER'S NAME: <u>Wallaceeson Curry</u>				14. MOTHER'S MAIDEN NAME: <u>Francenia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>***</u>				16. SOCIAL SECURITY NO. <u>*****</u>			
17. INFORMANT & ADDRESS: <u>Mrs Oran R. Wilkerson Calif. Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Congestive Heart Failure</u>						3 months	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1951, to <u>Feb. 12</u> , 1953, that I last saw the deceased alive on <u>Feb 12</u> , 1953, and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. C. Boyd</u>		ADDRESS <u>1100 Leonardtown</u>		DATE SIGNED <u>2/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/14/55</u>		REGISTRAR'S SIGNATURE <u>R. F. Locke</u>		24. FUNERAL DIRECTOR <u>Jos. C. Mattingley</u>		ADDRESS <u>Leonardtwn, Md.</u>	

BUREAU V. S.

FEB 28 1955

RECEIVED

01943

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1956

## CERTIFICATE OF DEATH

Reg. Dist. No.

282

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Mary's</i>	
CITY (If outside corporate limits, write nearest town) <i>Leonardtown</i>		RURAL <input checked="" type="checkbox"/> LENGTH OF STAY (in this place) <i>2 day's</i>		CITY (If outside corporate limits, write nearest town) <i>Rural Leonardtown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St Mary's Hospital</i>				STREET ADDRESS (If rural give location) <i></i>			
3. NAME OF DECEASED: (First) <i>Infant</i> (Middle) <i>Stone</i> (Last) <i>Stone</i>		4. DATE (Month) <i>Feb.</i> (Day) <i>20</i> (Year) <i>1955</i>		5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH: <i>Feb. 18, 1955</i>		9. AGE last birthday <i>2</i> yrs. IF UNDER 1 YEAR: Months <i>2</i> Days <i>2</i> Hours <i></i> Min. <i></i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i></i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Joseph F. Lord</i>		14. MOTHER'S MAIDEN NAME: <i>Elise Elizabeth Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT & ADDRESS: <i>Joseph F. Stone Leonardtown, Md.</i>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <i>760.5</i>				(A) <i>Cerebral (intracranial hemorrhage) &amp; D.</i>			
ANTECEDENT CAUSE (S) <i></i>				(B) <i></i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i></i>				(C) <i></i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Premature baby - birth wt 3-3"</i>							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION <i></i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <i></i>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i></i>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i></i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i></i>			
22. I hereby certify that I attended the deceased from <i></i> , 19 <i></i> , to <i></i> , 19 <i></i> , that I last saw the deceased alive on <i></i> , 19 <i></i> , and that death occurred at <i></i> , M. from the causes and on the date stated above.							
SIGNATURE <i>Ray E. Gentry, M.D.</i>		ADDRESS <i>Mechanicville, Md 21041</i>		DATE SIGNED <i>2/20/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/21/55</i>		NAME OF CEMETERY OR CREMATORY <i>St. Alex's</i>		LOCATION (City, town, or county) (State) <i>Leonardtown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4/20/55</i>		REGISTRAR'S SIGNATURE <i>Robert J. Locke</i>		24. FUNERAL DIRECTOR <i>John C. Mattingly</i>		ADDRESS <i>Leonardtown Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

2025316321

RECEIVED  
FEB 24 1955  
BUREAU V. 1

1957  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01944  
Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Saint Mary's</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Saint Mary's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>(Rural) Hollywood</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Hollywood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Sandy Bottom</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Lewis</u>		(Middle) <u>William</u>		(Last) <u>Sween</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12/25/1916</u>	
				9. AGE last birthday: <u>38</u> yrs.		4. DATE OF DEATH <u>February 14</u> 19 <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country): <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Lawrence Sween</u>				14. MOTHER'S MAIDEN NAME: <u>Minette Gyndolyn Harring</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>Present</u>		16. SOCIAL SECURITY No.: <u>-----</u>		17. INFORMANT & ADDRESS: <u>Navy Records;; Patuxent River, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Int. sanguification</u> DUE TO						15 min.	
Antecedent cause(s) (b) <u>shot gun wound of neck.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						15 min.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION: <u>none</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) <u>Sandy Bottom, St. Mary's</u> (County) <u>St. Mary's</u> (State) <u>MD</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>14</u> <u>55</u> <u>P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Accidentally shot handling gun.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/15/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/18/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>2/16/1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>P.B. Robinson</u>		ADDRESS <u>;; Leonardtown, Maryland.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED FEB 21 1952

RECEIVED FEB 21 1952

BUREAU V. S.

FEB 21 1952

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1958

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01945  
Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>ST. MARY'S</b> MARYLAND				STATE <b>MARYLAND</b> COUNTY <b>ST. MARY'S</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> TOWN <b>RURAL</b> <b>DRAYDEN</b>				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>RURAL</b> <b>DRAYDEN</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <b>1</b>			
3. NAME OF DECEASED:		(First) <b>DALLAS</b>		(Middle) <b>E.</b>		(Last) <b>TAYLOR</b>	
(Type or Print)						4. DATE OF DEATH <b>FEB. 17, 19 55</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>COLORED</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>WIDOWED</b>	8. DATE OF BIRTH: <b>APRIL 14, 1886</b>		9. AGE last birthday: <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>FARM</b>		11. BIRTHPLACE (State or foreign country): <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>FRANK TAYLOR</b>				14. MOTHER'S MAIDEN NAME: <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>**</b>		16. SOCIAL SECURITY No.: <b>*****</b>		17. INFORMANT & ADDRESS: <b>ANNIE TAYLOR DRAYDEN, MARYLAND</b>			
(If Yes, give war or dates of service) <b>*</b>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
177X Immediate cause (a) <b>Carcinoma of prostate</b> DUE TO						2 yrs	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arteriosclerotic</b>							
19a. DATE OF OPERATION: <b>1953</b>		19b. MAJOR FINDING OF OPERATION: <b>Arteriosclerotic</b>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH: <b>none</b>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>none</b>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>John L. Davis</b>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <b>2/17/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>BURIAL</b>		DATE THEREOF: <b>2-21-55</b>		NAME OF CEMETERY OR CREMATORY: <b>ST. MARKS</b>		LOCATION (City, town, or county) (State): <b>VALLEY LEE, MD.</b>	
DATE REC'D BY LOCAL REG: <b>Feb 19/55</b>		REGISTRAR'S SIGNATURE <b>John L. Davis</b>		24. FUNERAL DIRECTOR: <b>JOS. C. MATTINGLEY</b>		ADDRESS: <b>LEONARDTOWN, MD.</b>	

M

1

RECEIVED JAN 25 1965

RECEIVED JAN 25 1965

RECEIVED JAN 25 1965

BUREAU V. S.

FEB 25 1965

RECEIVED

1959

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

COUNTY **St. Mary's**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Patuxent River**

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS **U. S. Naval Air Station Infirmary**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **St. Mary's**CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Lexington Park**STREET ADDRESS (If rural give location) **593 Chinlee Drive**

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**John****David****WILLIS**

4. DATE (Month)

(Day)

(Year)

OF DEATH:

**February 5,****1955**

## 5. SEX:

**Male**

## 6. COLOR OR RACE:

**Caucasian**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

**Single**

## 8. DATE OF BIRTH:

**5 February 1955**

## 9. AGE last birthday

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Mjn.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

**Maryland**

## 12. CITIZEN OF WHAT COUNTRY?

**U. S.**

## 13. FATHER'S NAME:

**John Henry WILLIS**

## 14. MOTHER'S MAIDEN NAME:

**Mary Agatha BISCOE**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**No**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

**Mrs. Mary Agatha WILLIS, 593 Chinlee Dr., Lexington Park, Maryland**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**768.0**

## IMMEDIATE CAUSE

(A) **SEPTICEMIA, Puerperal**

## ANTECEDENT CAUSE (S):

DUE TO

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

## INTERVAL BETWEEN ONSET AND DEATH

**4 hrs**

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒ NO ☐

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

## 21C. WHERE DID (City or town) (County) (State)

## 21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased

alive on , 19 , and that death occurred at **6:32PM**, from the causes and on the date stated above.SIGNATURE **S. Cassara****S. CASSARA, LT MC USNR**ADDRESS **USNAS**

DATE SIGNED

M. D. **INF, PAX RIV MD.****2 Feb 1955**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

**Removal****7 Feb 1955****U. S. Naval Hospital****Bethesda, Maryland**

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 8 1955  
BUREAU V. S.